

# Reducing reliance on medical locums: a practical guide for medical directors



# Introduction

**This best practice guide goes through steps which medical directors could take to help reduce their trust's spend on medical locums.** It includes a list against which you can check your trust is taking effective action and advice on where to start if you have yet to tackle your trust's over-reliance on medical locums. It distils the experience of trusts that have substantially cut their spend on medical locums.

Trusts should only use locums as a last resort to fill short-term staffing gaps after other options have been exhausted. This is because:

- locums are an expensive solution to staffing shortages; the 2015/16 bill for medical locums in the NHS in England was £1.3 billion, representing over a third of agency spend, or £51 per taxpayer
- their overuse can put care quality at risk; a stable workforce whose members have regular appraisals is most likely to deliver high quality care and achieve continuity of services.

Maintaining a stable medical workforce is challenging: doctors are highly mobile and many specialties and parts of the country face a shortage of trained medical staff. National action is being taken to tackle these shortages, but every trust needs to take steps now to wean itself from an over-reliance on medical locums filling short-term and long-term gaps. Better deployment of the existing workforce, led by medical directors, is key.

## Some trusts are substantially reducing medical locum spend

- **Barnsley Hospital** has reduced weekly medical locum spend by 40% between October 2015 and April 2016.
- **East Cheshire Hospital** has halved its weekly number of medical and dental price cap overrides since February 2016, despite the price cap reduction in April 2016.
- **Barts** has adjusted its temporary medical staff use from 50% bank, 50% locum in May 2015 to 65% bank, 35% locum in May 2016.

# Six steps to reducing reliance on locums



# Checklist: has your trust taken these actions?

## FOR AN IMMEDIATE IMPACT

**STEP 1.** Ensure that **board accountability** for locum spend is clearly defined and adequate management resources are allocated. A senior manager should be responsible for reducing medical locum spend (usually this is the medical director, supported by the finance director and HR director).

**STEP 2.** Collect weekly **data on locum usage** for all specialties and develop reporting templates and metrics, eg:

- ✓ 1 page monthly summary for the board
- ✓ 2–3 page weekly reports for the medical director, finance director and HR director.

**STEP 3.** Develop consistent policies on **finding alternatives** to using locums, and encourage buy-in from all teams:

- ✓ Share staff between specialties
- ✓ Establish and promote use of internal banks
- ✓ Flexibly deploy different grades of staff.

**STEP 4. Establish processes** for approving locum use:

- ✓ Standard form and checklist (preferably online) for requesting locum shifts
- ✓ A senior panel reviews locum requests and only a limited number of senior staff can approve requests
- ✓ Centralised locum booking and price negotiation.

## FOR AN IMPACT IN 3-6 MONTHS

**STEP 5.** Identify **underlying staffing issues and develop solutions:**

- ✓ Identify current and future staffing gaps by analysing workforce demand and capacity. This work should be led by senior clinical staff.
- ✓ Review and simplify recruitment processes
- ✓ Support staff to develop new operating models and innovative approaches to recruitment and retention
- ✓ Actively involve the board in workforce planning.

**STEP 6.** Set up a working group led by executives from trusts across your local area to **collectively tackle locum spend**. The group should decide:

- ✓ Consistent approaches to using frameworks, employing locums and using price overrides
- ✓ Common narrative when communicating with agencies and agency workers across the local area
- ✓ How to share staff.

# Medical directors take greater control of workforce

## GET STARTED

Ensure that **board accountability** for locum spend is clearly defined and adequate management resources are allocated. A senior manager should be responsible for reducing medical locum spend (usually this is the medical director, supported by the finance director and HR director).

Leadership must start right at the top with the chief executive and the medical director.

### What does leadership involve?

- Agreeing a plan with the board for achieving or maintaining sustainable medical staffing.
- Being informed about workforce issues by getting the right information through a clear governance process.
- Ensuring staff know where decision-making responsibility sits and are confident in the support of their executive and board when taking steps to reduce reliance on medical locums.

### Medical directors with a good grasp of their trust's use of medical locums should be able to answer the following questions:

- How many locum doctors were employed by your trust last week and why were they needed?
- Which locums are most expensive?
- Which services are most dependent on locums for their staffing?

### Medical directors need to be confident in the following processes for an effectively deployed workforce:

- You have control over the mechanism for using locums with a senior person signing off all spend.
- You have effective workforce planning – do you know how many medical staff are required for each specialty?
- Your trust exhausts all alternatives before using a medical locum.
- You work with your neighbours to get locums at best value.

### Case study: Establishing clear lines of governance

The **Paybill Reduction Group** at East Cheshire consists of the HR director, finance director, deputy medical director and a senior nurse.

The group meets weekly to review data, policies and processes on establishment, recruitment and retention, staff costs and agency booking trends, and commissions reviews of workforce policies and processes (eg leave booking processes).

Since it was set up, the group has significantly improved the quality of data collected and harmonised rostering, leave and agency booking processes to improve staff deployment across the trust.

# Collect timely and accurate data

## GET STARTED

Collect weekly data on locum usage for all specialties:

- |                        |                        |
|------------------------|------------------------|
| ✓ Specialty/ward/grade | ✓ Reason (eg sickness) |
| ✓ Date/time of shift   | ✓ Date of approval     |
| ✓ Price paid for shift | ✓ Name of approver     |
| ✓ Method of engagement | ✓ Name of locum        |

Develop clear reporting templates and metrics:

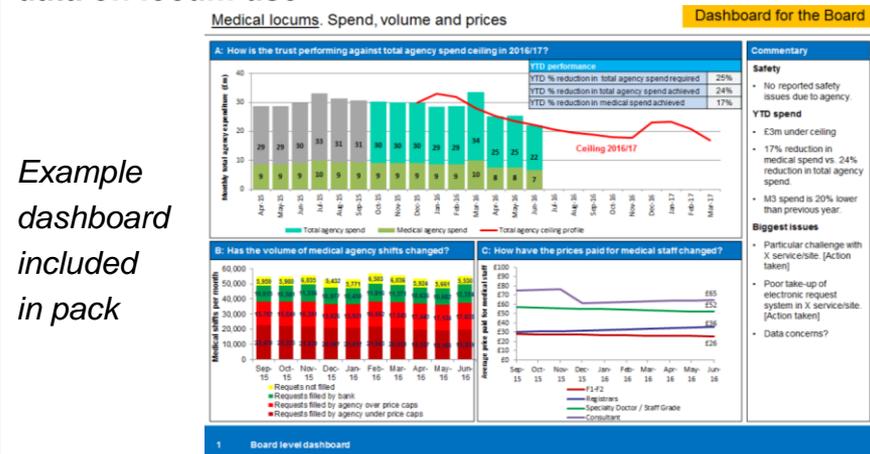
- ✓ 1 page monthly summary for the board
- ✓ 2–3 page weekly reports for the medical director, finance director and HR director.

Timely and accurate data, presented in a helpful way, can uncover real-time ward-level issues and solutions, such as:

- staff shortage hotspots – specialties and grades where services are at greatest risk, and causes that need to be addressed
- expensive and career locums who should be encouraged to take permanent roles
- best value methods for obtaining locum cover
- individuals working unsafe hours.

Good data can also hold senior managers to account for locum use and spending, and help staff develop solutions suited to their own specialties.

## Case study: Software packages can collate and present data on locum use



Example dashboard included in pack

Just collecting data is not enough. Its presentation must send clear messages to clinical teams, eg flagging payments above the agency price caps.

## Case study: One trust found evidence of locum misuse once they started collecting good quality data, including:

- locums paid over £10,000 per week
- locums working over 4,000 hours per year
- positions filled by locums (sometimes the same locum) for 3 years or more
- locum shifts booked more than 6 months in advance.

# Develop alternatives to using locums

## GET STARTED

Develop consistent policies on **finding alternatives** to using locums, and encourage buy-in from all teams:

- ✓ Share staff between specialties
- ✓ Establish and promote use of internal banks
- ✓ Flexibly deploy different grades of staff.

While every trust will face long-term and short-term workforce challenges, using a locum should always be a last resort after alternatives have been explored.

### First: move medical staff across wards

Barnsley Hospital uses a simple 'heat map' to identify staff surpluses (green) on the rota that can be reallocated to meet shortages (red) on other wards.

	Minimum	Monday		Tuesday		Wednesday		Thursday		Friday	
		Rota	Adj	Rota	Adj	Rota	Adj	Rota	Adj	Rota	Adj
Ward 1	2	4	3	3	3	1	2	3	2	3	2
Ward 2	3	1	3	2	3	4	3	4	3	3	3
Ward 3	1	1	1	1	1	0	1	1	1	1	1
Ward 4	3	4	3	5	4	4	3	1	3	2	3

Implementing electronic rostering or using existing rostering more effectively will identify surpluses and shortfalls.

You may be able to schedule a "floating week" in your junior doctor rotas, which will allow you to move staff between wards to cover exceptional periods. Doctors like this arrangement but you may need approval from deaneries/foundation schools.

### Second: promote internal banks

Always use internal bank staff if available before resorting to locum staff. Trusts can increase participation in banks through:

- auto-enrolment of staff
- weekly payment for shifts, rather than monthly
- active recruitment of non-substantive doctors to banks, eg some trainees will want temporary work from a trust after their placement ends. Non-substantive staff often choose to do more bank hours than substantive staff.

Trusts can promote bank staff use among managers by simplifying the engagement process – it must be easier to request bank staff than locum staff.

### Third: use different grades of doctors

East Cheshire's Deputy Medical Director asks divisional clinical leads to step down to provide clinical cover when an alternative to a locum or a locum at below price cap rates cannot be found. This approach can be more cost-effective than resorting to locums and reduces clinical risk to the trust.

# Introduce formal processes for requesting locums

## GET STARTED

Establish processes for approving locum use:

- ✓ Standard form and checklist (preferably online) for requesting locum shifts
- ✓ A senior panel reviews locum requests and only a limited number of senior staff can approve requests
- ✓ Centralised locum booking and price negotiation.

A trust's process for requesting medical locum cover needs to be documented and all teams informed about it. The process should challenge clinical leads to consider if cover is really needed. Where it is, the process should support clinical leads in making sure all alternatives are first ruled out and in getting the best value.

## Case study: Centralised locum booking and payment

Derby has centralised its locum booking. The dedicated central team negotiates agency rates for all divisions, using the agency price caps as a negotiation tool.

This is a model developed from that used by the nursing directorate; the central booking team now covers both medical and nursing bookings.

A central team is also well placed to collate and present the data required to keep track of progress.

## Case study: Standardised forms and panels for locum requests

Medical teams at Barnsley Hospital must **submit a locum request form** in advance of making a booking, regardless of the price to be paid.

Barnsley locum request form – full template on [page 12](#)

**Requester/Coordinator**

Name	Job Title	Requesting for use in

**Requesting for use in**

Area		

**Reason for request**

**Medical Staffing - MDTA COORDINATOR ACTION**

Requester/Coordinator	Requesting for use in	Medical Staffing - MDTA COORDINATOR ACTION

A **locum review panel**, consisting of the medical director, finance director and HR director, then scrutinises each request. Divisional clinical leads must attend to justify their locum requests.

The trust found that by implementing a form and requiring managers to justify their requests to a panel, managers gave more thought to whether a locum was really needed. The panel initially met daily but now meets fortnightly with the establishment of the system the number of requests has fallen.

Larger trusts may prefer to set up similar panels in each hospital or only scrutinise a sample of requests in this way.

# Reduce future reliance on locums

## GET STARTED

Identify underlying staffing issues and develop solutions:

- ✓ Identify current and future staffing gaps by analysing workforce demand and capacity. This work should be led by senior clinical staff.
- ✓ Review and simplify recruitment processes
- ✓ Support staff to develop new operating models and innovative approaches to recruitment and retention
- ✓ Actively involve the board in workforce planning.

High locum usage should prompt managers to look for ways to plan their workforce better.

**Start with a staffing stocktake – divisions need to do proper demand and capacity analysis and workforce planning.**

Workforce planning needs to:

- start from future demand and commissioning intentions for the service
- be informed by good data on workload
- be done by a team of senior clinical leads and service managers.

NHS Employers provides a [guide to workforce planning](#) and runs courses to support medical directors and consultants.

## Case study: Innovative approaches to recruitment

Dr Dan Boden, Emergency Medicine Consultant at Derby Hospital, set up [Certificate of Eligibility for Specialist Register](#) (CESR) posts as a response to high vacancy and sickness rates at junior doctor level. These provide professional development and progression for junior doctors outside an official training programme through mentoring, protected training time and budget, and rotations across other specialities.

The trust now has a waiting list of junior doctors wanting to work in the ED, significantly improved job satisfaction and reduced sickness rates.

Listen [here](#) to Dr Boden talk about the scheme and its impacts.

## Case study: Introducing new staffing models

University Hospitals of Leicester assembled a team of advanced nurse practitioners and specialist nurses in cardiology and respiratory medicine to work in its busy cardiorespiratory admissions unit. Leicester is piloting a model in which these staff work with a GP to assess those patients who are unlikely to require admission to an ambulatory clinic. This has freed medical staff to spend more time on complex cases and improving patient care.

# Work supportively with your local neighbours

## GET STARTED

Set up a working group led by executives from trusts across your local area to **collectively tackle locum spend**. The group should decide on:

- ✓ Consistent approaches to using frameworks, employing locums and using price overrides
- ✓ Common narrative when communicating with agencies and agency workers across the local area
- ✓ How to share staff.

Trusts can reduce their reliance on locums by acting individually, but more can be achieved through working with other trusts in your local area to better understand demand and supply of staff and to keep down locum prices.

This is particularly important for medical locums who are often more mobile than agency nurses.

## Case study: Aligning locum request and override principles across local trusts

Bedfordshire and Hertfordshire have developed cross-trust working groups to voluntarily agree common policies and procedures, including:

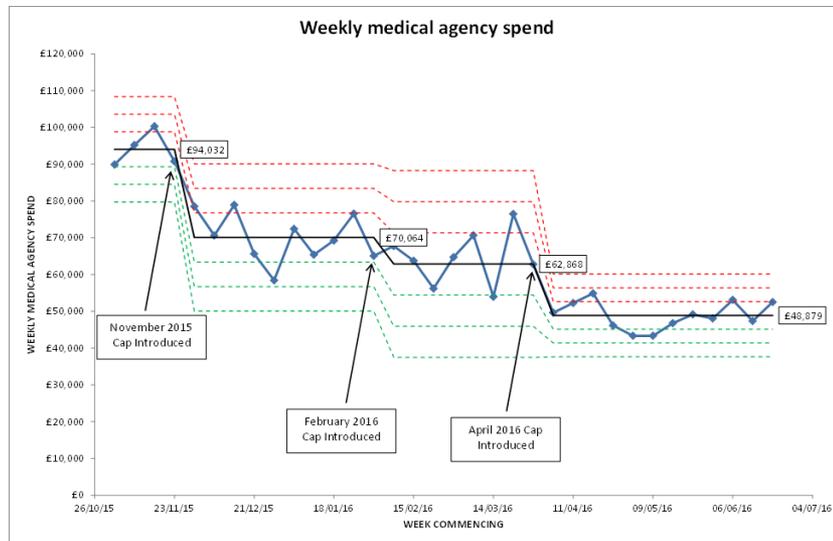
- common narrative when communicating with agency workers and agencies
- aligned governance processes around overrides and a common approach to overrides where needed on safety grounds
- use of the same frameworks across the area
- a policy of not using substantive/bank staff from a neighbouring trust to encourage workers to work for their own trust's bank
- running mini competitions to lower the rates paid for agency workers. The hub has set up a system where agencies that can supply medical staff at or below 1 April price cap levels are awarded 'tier 1 status' and receive more advanced notice of shifts.

They have formed working groups for different staff groups to raise and tackle shared issues, such as problems with specific agencies. They have been able to make good progress on their total agency spend because of the senior buy-in from the trusts.

# Case study: Barnsley Hospital NHS Foundation Trust

Barnsley Hospital NHS Foundation Trust is a small single site DGH in South Yorkshire. It is close to the M1 motorway with around 15 other hospitals within a 1 hour drive distance.

The trust has reduced both the number of shifts and prices paid per shift at consultant level and prices paid per shift at SHO level. The trust still faces challenges in recruiting middle-grade doctors.



Barnsley is targeting further reductions in medical agency spend in 2016/17 through alternative workforce solutions and employment of flexible cover doctors linked to in-house training opportunities.

## How did Barnsley do it?

When the medical director started collecting medical staffing information to present to the board (similar to the nursing staffing ratios the nursing director provided), he realised that medical locum usage was very high and that reliance on locums had become the norm in some specialities, such as emergency medicine. Some of this was due to fundamental supply shortages but in other cases it was driven by culture.

The medical director introduced:

1. real-time, ward-level information on staffing levels which is used to construct 'heat-maps' of staffing issues
2. a locum request panel made up of senior staff and chaired by the medical director to challenge locum requests, and to prompt divisional clinical leads and managers to think whether locums were actually required
3. a locum request form that forced clinical and operational leads to think about alternatives before resorting to locum use
4. a recruitment drive targeted at gaps identified from the data and locum request panel process, to reduce reliance on temporary staffing. Some specialties had previously been unsuccessful in recruiting to middle-grade and junior doctor rotas and had started to rely on locums instead of continuing to try and recruit substantively. These posts were again put out to recruitment with success in many specialties. No incentives were used to recruit staff.

# Case study: Barnsley's locum request form

## Checklist

Please note that this must be completed for all requests. Following consultation with the rota coordinator, please indicate the action taken against each of the following to confirm which options have been considered. Please state why these options are not viable if they are not possible.

Options Considered	Yes / No	Reasoning for yes / no
Re-arranging Rota		
Alternative Internal Arrangements e.g. temporary redistribution of staff from other areas		
Internal medical bank		
Recall of doctors on annual / study leave		
Using other grades of doctor to cover gap		
Increasing hours of part time colleagues to cover the gap		
Other – please give details		

Clinical Business Unit	Specialty						
Ward/Dept	Cost Code						
Grade	Consultant	SD / AS	ST3+/CT3	ST2/CT2	ST1/CT1	FY2	FY1

## Short Term Requirements (individual shifts to be covered)

	Grade	Date	Times	Reason for request (E.G. Sickness / Vacancy)	If a vacancy, What Post does this relate to?	When will the vacancy be filled?	If Sickness To cover Whom?
Shift 1		/ /					
Shift 2		/ /					
Shift 3		/ /					
Shift 4		/ /					
Shift 5		/ /					
Shift 6		/ /					
Shift 7		/ /					

Note: The maximum number of shifts per short-term request is seven.

## Long Term Requirements (for periods in excess of one week)

Grade	Date From	Date To	Will they work specific times or are they covering a timetable to cover the gap in full?	Reason for request e.g. sickness, vacancy?	If a vacancy, when will the vacancy be filled?	If Sickness who is it covering?

If the initial request is received verbally, suitable doctors will be sourced but please note **no booking will be confirmed**, unless the request needs genuine immediate action due to patient safety concerns. This form will still need to be completed at the earliest possible opportunity.

## CLINICAL BUSINESS UNIT MANAGER DECLARATION

I confirm that I am satisfied that all alternative options to cover the absence have been considered and I am fully aware of the cost implications to my budget

Name	E-Signature	Date
	I request the sourcing and booking of internal or agency locum staff for the period identified above	

Once complete, e-mail to the Director

## DIRECTOR DECLARATION

I confirm that I am satisfied that all alternative options to cover the absence have been considered and that a locum should be obtained

Name	E-Signature	Date
	Authority is hereby granted to proceed as detailed in this request	

Please forward the completed e-form to Medical Staffing Rota Coordinators team at [xxx@nhs.net](mailto:xxx@nhs.net) or to your individual rota coordinator if they are not part of the central team. Please note that the rota coordinators will need to keep these records therefore forms must be completed and returned to the rota coordinator.

## MEDICAL STAFFING / ROTA COORDINATOR ACTION

Has the best option been taken Yes/No  
If no what could have been done?

Agency(ies) used	Name(s) of Doctor(s) Booked	Confirmation sent via email Date and time	Hourly rate of booked doctor

Distribution: CBU Manager, CBU Finance Manager, Switchboard and Rota Coordinator.

Name	E-Signature	Date
	E-signature- certified all action has been completed in respect of this request	